

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05584

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Denton		c. LENGTH OF STAY IN 1b life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Denton			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS J			
3. NAME OF DECEASED (Type or print) George Washington Beck				4. DATE OF DEATH Month May Day 3, Year 19 60			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Mar. 15, 1898	9. AGE (In years last birthday) 62 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dealer, garage owner		10b. KIND OF BUSINESS OR INDUSTRY Auto		11. BIRTHPLACE (State or foreign country) Maryland			
13. FATHER'S NAME Josiah Beck				14. MOTHER'S MAIDEN NAME Bertha Roe			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Address George W. Beck, Jr., Denton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Heart disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH Sudden		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE Dawson O. George M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) PAWSON O. GEORGE				DATE SIGNED 5-4-60			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF May 6, 1960		22c. NAME OF CEMETERY OR CREMATORY Denton			
22d. LOCATION (City, town, or county) Denton, Md.				(State)			
23. FUNERAL DIRECTOR'S SIGNATURE [Signature]			24a. REC'D BY REGISTRAR [Signature]				
24b. REGISTRAR'S SIGNATURE Arthur S. Hume			DATE MAY 11 '60				

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 1B. Give Pages 1, 2, and 3 to the Registrar. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05585

5610

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Caroline</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Federalsburg</u>				c. LENGTH OF STAY IN 1b <u>18 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>308 South Main Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Alva</u> Last <u>Coulbourn</u>				4. DATE OF DEATH Month <u>May</u> Day <u>13</u> Year <u>19 60</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 10, 1882</u>	9. AGE (In years last birthday) <u>78</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Night Watchman at Excelsior Pearl Works</u>
10b. KIND OF BUSINESS OR INDUSTRY <u>Dorchester Co., Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Eugene L. Coulbourn</u>				14. MOTHER'S MAIDEN NAME <u>Linda Thomas</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <u>No</u>				16. SOCIAL SECURITY NO. <u>220-12-2175</u>			
17. INFORMANT <u>Mrs. Reva Taylor Coulbourn</u>				Address <u>Federalsburg, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> <u>177X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Carcinoma, prostate</u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u> </u>							
INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u> <u>unknown</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>May 9, 1960</u> , to <u>May 12, 1960</u> that I last saw the deceased alive on <u>May 9, 1960</u> , and that death occurred at <u>1:50 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>126 Bloomingdale Avenue</u> DATE SIGNED <u>5-16-60</u>							
ACTUAL SIGNATURE <u>H. R. Trapnell</u> M.D. <u>126 Bloomingdale Avenue</u> DATE SIGNED <u>5-16-60</u>							
PHYSICIAN'S NAME (Type) <u>H. R. Trapnell, M.D.</u> <u>Federalsburg, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>May 16, 1960</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Hill Crest Cemetery</u>				22d. LOCATION (City, town, or county) (State) <u>Federalsburg, Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Frampton and Son, Federalsburg, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 18 '60</u>			
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>				24c. REGISTRAR'S SIGNATURE			

STATE OF TEXAS
COUNTY OF DALLAS

1910

STATE OF TEXAS
COUNTY OF DALLAS

BEFORE ME, the undersigned authority, on this _____ day of _____, 1910, personally appeared _____, known to me to be the person whose name is subscribed to the foregoing instrument, and acknowledged to me that he executed the same for the purposes and consideration therein expressed.

Given under my hand and seal of office this _____ day of _____, 1910.

Notary Public in and for the State of Texas

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5614

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05586

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CAROLINE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution, Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CAROLINE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL DENTON</u>		c. LENGTH OF STAY IN 1b <u>38 yrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>DANIEL DONORAN HOLLINGSWORTH</u>		4. DATE OF DEATH Month Day Year <u>MAY 12 1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV 7, 1851</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WILLIAM HOLLINGSWORTH</u>		14. MOTHER'S MAIDEN NAME <u>MOORE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Daniel D. Hollingsworth, Jr.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured Cervical Vertebrae</u> DUE TO <u>Fractured Left Arm</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>Lacerations & Contusions</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Alcohol Caught in Shaft of Elevator (Corn)</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>May 12 1960</u>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Farm</u>		20f. City or town <u>Ridgely</u> (County) <u>Caroline</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Dawson O. George</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Dawson O. George MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 16, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cheslerfield</u>		22d. LOCATION (City, town, or county) (State) <u>Centerville</u> <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Moore + Son Denton</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	
DATE <u>MAY 20 '60</u>			

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Bloomingdale Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Robert Middle Leonard Last Magee, Sr.		4. DATE OF DEATH Month May Day 23 Year 19 60	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 11, 1893
9. AGE (In years lost birthday) yrs. 66		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Day Laborer in Private Home (Domestic)		10b. KIND OF BUSINESS OR INDUSTRY Caroline Co., Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Magee		14. MOTHER'S MAIDEN NAME Manzella Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-03-9654	
17. INFORMANT Maxine Magee, Federalsburg, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Artery DUE TO (c) Arteriosclerotic Heart Disease INTERVAL BETWEEN ONSET AND DEATH ? ? ?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 23 , 19 60 , to May 23 , 19 60 , that I last saw the deceased alive on May 23 , 19 60 , and that death occurred at 3 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Federalsburg, Md DATE SIGNED 5-25-60			
ACTUAL SIGNATURE H. R. Trapnell M.D.		PHYSICIAN'S NAME (Type) H. R. Trapnell, M.D. Federalsburg, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 25, 1960	
22c. NAME OF CEMETERY OR CREMATORY Federal Hill Cemetery		22d. LOCATION (City, town, or county) (State) Federalsburg, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Frampton and Son, Federalsburg, Maryland		24a. REC'D BY REGISTRAR DATE MAY 31 '60	
24b. REGISTRAR'S SIGNATURE Charles S. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

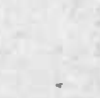
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 05588

5612

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg		c. LENGTH OF STAY IN 1b Full Life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Bessie Middle B. Last Marine		4. DATE OF DEATH Month May Day 20 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 8, 1884
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		12. KIND OF BUSINESS OR INDUSTRY housewife	
13. BIRTHPLACE (State or foreign country) Maryland		14. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. FATHER'S NAME Charles A. Brown		16. MOTHER'S MAIDEN NAME Mary F. Hurlock	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		18. SOCIAL SECURITY NO. none	
19. INFORMANT Miss Mary Marine		Address Federalsburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis Acute DUE TO (b) Arterio Sclerosis General DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH Sudden Several Yrs			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Dawson O. George		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Dawson O. George		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 23, 1960	
22c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery		22d. LOCATION (City, town, or county) (State) Federalsburg Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Thomas		24a. REC'D BY REGISTRAR DATE MAY 24 '60	
		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO DEATH MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: [illegible]
2. AGE: [illegible]
3. SEX: [illegible]
4. RACE: [illegible]
5. OCCUPATION: [illegible]
6. PLACE OF BIRTH: [illegible]
7. DATE OF BIRTH: [illegible]
8. DATE OF DEATH: [illegible]
9. TIME OF DEATH: [illegible]
10. PLACE OF DEATH: [illegible]
11. CAUSE OF DEATH: [illegible]
12. MANNER OF DEATH: [illegible]
13. SIGNATURE OF EXAMINER: [illegible]
14. DATE OF EXAMINATION: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1 *P*
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

5613

05589

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greensboro		c. LENGTH OF STAY IN 1b 65 Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George Middle W. Last Murray		4. DATE OF DEATH Month 5 Day 19 Year 19 60	
5. SEX Male	6. COLOR OR RACE Col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-11-1893
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer Canning Co.		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George W. Murray		14. MOTHER'S MAIDEN NAME No Record	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-07-3403	
17. INFORMANT Catherine Patterson Greensboro, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Nephritis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) General Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Alcoholism		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 16, 1960 to May 19, 1960 , that (I) (we) last saw the deceased alive on May 19, 1960 , and that death occurred at 5:30 P from the causes and on the date stated above.			
22a. SIGNATURE Charles H. Stoner		22b. DATE SIGNED May 20, 1960	
22c. PHYSICIAN'S NAME (Type) Charles H. Stoner, M.D.		22d. ADDRESS Greensboro, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-22-60	
23c. NAME OF CEMETERY OR CREMATORY Cokers		23d. LOCATION (City, town, or county) (State) Near Greensboro, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE J. E. Boulais		25a. REC'D BY REGISTRAR DATE MAY 24 '60	
ADDRESS Greensboro, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	

(M)

(1)

1913

CERTIFICATE OF DEATH

10579

Caroline

May 10

Grand Rapids

62 Yrs. 6 Months

John

John

George

George

Male

11-11-1852

Married

Married

George W. Murray

Ed. Murray

217-00-100 Catherine Patterson

John W. Patterson

John W. Patterson

John W. Patterson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

5615

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05590

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Ridgely		c. LENGTH OF STAY IN 1b 70 Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Ridgely			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None				d. STREET ADDRESS None		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Charles Slow				4. DATE OF DEATH Month Day Year 5 13 19 60			
5. SEX Male		6. COLOR OR RACE Col.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-19-1869	
9. AGE (In years last birthday) 90 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Laborer		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME No Record				14. MOTHER'S MAIDEN NAME No Record			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Margie Matthews Greensboro, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Apr. 2 1959 to May 13 1960 , that (I) (we) last saw the deceased alive on May 12 1960 and that death occurred at 11:30 a. m. from the causes and on the date stated above.							
22a. SIGNATURE Charles H. Stoner M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 5/14/60			
22c. PHYSICIAN'S NAME (Type) Chas. H. Stoner, M.D.				22d. ADDRESS Greensboro, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-17-60		23c. NAME OF CEMETERY OR CREMATORY Denton		23d. LOCATION (City, town, or county) (State) Denton, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE J. E. Boulais				ADDRESS Greensboro, Md.		25a. REC'D BY REGISTRAR DATE MAY 17 '60	
				25b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

100-300000

CERTIFICATE OF DEATH

100-300000

Decedent's Name

John Doe

Decedent's Name

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

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1

John Doe

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John Doe

John Doe

John Doe

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05591

5609

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CAROLINE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CAROLINE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DENTON</u>				c. LENGTH OF STAY IN 1b <u>50 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>WESLEY EARLE THAWLEY</u>				4. DATE OF DEATH Month Day Year <u>MAY 22 1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT 13, 1895</u>	9. AGE (In years last birthday) <u>64</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attorney</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Law</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ROBERT H. THAWLEY</u>				14. MOTHER'S MAIDEN NAME <u>LENA J. CAHALL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>WW I</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Robert H. Thawley, Denton, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of Lung</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>5 months</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <u>19</u>			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>January 19, 1960</u> to <u>May 22, 1960</u> that I last saw the deceased alive on <u>May 22, 1960</u> , and that death occurred at <u>11:25 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Newton O. George M.D.</u>				ADDRESS (Street, city or town, state) <u>Denton, Maryland</u>			
PHYSICIAN'S NAME (Type) <u>NEWTON O. George M.D.</u>				DATE SIGNED <u>May 25, 1960</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 25, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Denton</u>		22d. LOCATION (City, town, or county) (State) <u>Denton, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Moore</u>				ADDRESS <u>Denton, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE JUN 1 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>			

CERTIFICATE OF DEATH

2008

NAME OF DECEASED <u>WILLIAM J. HARRIS</u>		SEX <u>Male</u>	
DATE OF BIRTH <u>10/15/1925</u>		PLACE OF BIRTH <u>St. Louis, Mo.</u>	
OCCUPATION <u>Retired</u>		MARITAL STATUS <input checked="" type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
STREET ADDRESS <u>1000 N. E. St.</u>		CITY <u>Baltimore</u>	
STATE <u>MD</u>		ZIP CODE <u>21201</u>	
DATE OF DEATH <u>10/15/2008</u>			
TIME OF DEATH <u>10:00 AM</u>			
PLACE OF DEATH <input checked="" type="checkbox"/> At Home <input type="checkbox"/> Hospital <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other			
NAME OF PHYSICIAN <u>Dr. J. H. Smith</u>			
NAME OF HOSPITAL <u>St. Joseph's Hospital</u>			
NAME OF NURSING HOME <u>None</u>			
NAME OF OTHER PLACE <u>None</u>			
CAUSE OF DEATH <u>Heart Disease</u>			
MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined			
SIGNATURE OF PHYSICIAN <u>J. H. Smith</u>			
SIGNATURE OF DECEASED <u>None</u>			
SIGNATURE OF WITNESS <u>None</u>			
SIGNATURE OF REGISTRAR <u>None</u>			

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE, MD. IT IS NOT VALID FOR OTHER PURPOSES.

TO HOST: OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05592

5616

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>CAROLINE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CAROLINE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Denton</u>	c. LENGTH OF STAY IN 1b <u>life</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Rural Denton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>MAJOR</u> First <u>LEE</u> Middle <u>WYATT</u> Last		4. DATE OF DEATH <u>MAY 23</u> Month <u>23</u> Day <u>19</u> Year <u>60</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG 5, 1876</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>farmer</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>JOHN R. WYATT</u>	
14. MOTHER'S MAIDEN NAME <u>ANNIE BUTLER</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Mrs Lee Wyatt Denton</u> Address <u>Denton Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>331X</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>4 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April 22, 1960</u> to <u>May 22, 1960</u> , that I last saw the deceased alive on <u>May 22, 1960</u> , and that death occurred at <u>9 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Lawson O. George</u> M.D.		ADDRESS (Street, city or town, state) <u>Denton, Maryland</u> DATE SIGNED <u>May 25, 1960</u>	
PHYSICIAN'S NAME (Type) <u>DAWSON O. George M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>May 26, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Denton</u>	22d. LOCATION (City, town, or county) (State) <u>Denton, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Frame</u> ADDRESS <u>Denton</u>		24a. REC'D BY REGISTRAR <u>JUN 1 '60</u> DATE	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frame</u>

CERTIFICATE OF DEATH

1918

1918

<p>NAME OF DECEASED <i>John Doe</i></p>		<p>AGE <i>45</i></p>		<p>SEX <i>Male</i></p>		<p>RACE <i>White</i></p>	
<p>DATE OF DEATH <i>Jan 15 1918</i></p>		<p>TIME OF DEATH <i>10:30 AM</i></p>		<p>PLACE OF DEATH <i>Home</i></p>		<p>Cause of Death <i>Heart Disease</i></p>	
<p>Signature of Physician <i>John Doe</i></p>		<p>Signature of Registrar <i>John Doe</i></p>		<p>Signature of Coroner <i>John Doe</i></p>		<p>Signature of Burial Officer <i>John Doe</i></p>	
<p>Signature of Medical Examiner <i>John Doe</i></p>		<p>Signature of Health Officer <i>John Doe</i></p>		<p>Signature of City Clerk <i>John Doe</i></p>		<p>Signature of County Clerk <i>John Doe</i></p>	